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Society of Hospital Medicine

2023 State of Hospital Medicine Report

2023 Report based on 2022 Data

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Acknowledgments

SHM extends a special thanks to the following members who contributed their expertise and perspectives to the 2023 *State of Hospital Medicine* Survey and Report.

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Important Notices

This Report contains data derived from SHM's *State of Hospital Medicine* and *Hospital Medicine Workforce Experience* Surveys and the MGMA's *Physician Compensation and Production* Survey. All survey results and information obtained from statistical analysis of the results are the proprietary and confidential property of SHM and MGMA, as applicable.

Confidentiality

Information provided by *State of Hospital Medicine* and *Hospital Medicine Workforce Experience* Survey respondents is held strictly confidential and is reported only in aggregate form alongside data submitted by the other respondents. Only SHM staff see individual survey responses. Results are published in summary form only, and table cells with a low number of responses were omitted to protect the identity of individual survey respondents.

Intended Use

This Report, and the information contained in it, is intended to educate readers about characteristics and trends in the rapidly evolving specialty of hospital medicine. This data may not be used for limiting competition, restraining trade, or reducing or stabilizing compensation or benefit levels. Neither SHM nor MGMA render any legal, accounting, or professional advice that might be construed as applicable to specific situations.

Limitations of Survey Data

Users should bear in mind that the information presented in this Report is based on voluntary survey responses provided primarily by members of SHM and MGMA. The data have not been independently validated and may not be representative of all hospital medicine practices. Because the respondent pools for the SHM *State of Hospital Medicine* Survey, *Hospital Medicine Workforce Experience* Survey, and the MGMA Survey are different, and respondent pools vary from year to year within each survey, comparison of results between the SHM and MGMA surveys or conclusions about longitudinal trends or year-to-year fluctuations may not be accurate.

Table of Contents

Note: *Appendices C and D are available in the electronic version only. To reference either instrument, please go to hospitalmedicine.org/sohm.*

Tables in each subsection

[i]*Scope of Clinical Services includes: Co-Management Roles, Novel Scopes of Practice, Uses of Telehealth*

[ii]*Staffing Includes: FTE Staff per Group, Ratio of Support Staff per FTE Physician, Source of New Physicians, Percent of Physicians Joining from Residency, Percent of Physicians that were Part-Time Status, Percent of Physicians in the Group Who are Board Certified in PHM (Section 4 only), Turnover by Type of Clinician, Average Physician Turnover Rate, Anticipated Change of Budgeted FTE, Presence and Billing for NPs/PAs, NP/PA Non-Billable Services, Percent of Time on Non-Billable Services*

[iii]*Leadership includes: Total Number of Physician Leaders, Total Dedicated FTE Allocation for All Physician Leaders, Ratio of Leadership FTE to Physician Hospitalists FTE, Highest-Ranking Physician Leader—Percentage of FTE Dedicated to Leadership, Highest-Ranking Physician Leader Percent Compensation Premium, Demographic Information about Highest-Ranking Physician Leader, Burnout and Well-being*

[iv]*Scheduling includes: Staffing Backup Systems, Staffing Backup System Incentives, Duration of Shifts in Hours, Duration of Shifts in Hours by Employment Model (Section 3 only), Duration of Day Shifts by Group Size (Section 4 only), Annual Number of Shifts or Work Periods for a Full-Time Hospitalist, Number of Clinical Hours Required for a 1.0 FTE Physician (Section 4 only), Offering Paid Time off (PTO), Scheduling Changes Made in Last Year, Flexibility for Work to be Completed Off-Site, Unfilled Physician Hospitalist Positions in Groups, Contributing Factors for Unfilled Positions, Coverage for Unfilled Positions, Predominant Scheduling Patterns, Predominant Scheduling Patterns by Year, Predominant Night Coverage Model, Presence of On-Site Night Coverage Models Using On-Call Hospitalists, Nocturnist Presence and Differentials, Percent Fewer Shifts in Nocturnist Schedule with a Differential, Percent Higher Compensation in Nocturnist with a Pay Differential, Presence of a Daytime Admitter Model, Utilization of Unit-Based Assignments*

[v]*Group-Level Compensation and Benefits includes: Components of Hospitalist Compensation, Use of Differentials for Years of Service, Use of Performance Incentive Measures in Compensation Plan, Value of Annual Employee Benefits, Employee Benefits Offered, Annual CME Allotment per FTE Hospitalist*

[vi]*Billing includes: Reporting of Measures in Medicare Merit-based Incentive Payment System (MIPS), Participation in Medicare Advanced Alternative Payment Models, Receipt of Incentive Payments on Medicare Part B Payments for Participation*

[vii]*Academic HMGs includes: Amount of Financial Support per FTE for Non-Clinical Work in Academic HMGs, Distribution of Work in Academic HMGs, Requirements for Academic Appointments at Affiliated Institution (Section 4 only), Salary Increase Associated with Academic Promotion*

[viii]*Practice Finances includes: Amount of Financial Support per FTE Employed Physician, Amount of Financial Support per FTE Provider (All Provider Types), Amount of Financial Support per wRVU*

[ix]*Section 5 contains provider-level productivity and compensation data. Each subsection is arranged identically. Tables in each subsection of Section 5 include:*

Non-Academic: *Compensation (Table a), Retirement Benefits (Table b), Collections for Professional Charges (Table c), Gross Charges (Table d), Total Encounters (Table e), Work RVUs (Table f), Compensation to wRVUs Ratio (Table g), Collections to wRVUs (Table h), wRVUs to Total Encounters (Table i), Collections to Total Encounters (Table j), Compensation to Total Encounters (Table k)*

Academic (Adult IM and Pediatric): *Compensation (Table a), Collections for Professional Charges (Table b), Gross Charges (Table c), Total Encounters (Table d), Work RVUs (Table e), Compensation to Total Encounters Ratio (Table f), Compensation to wRVUs Ratio (Table g), Collection to Total Encounters Ratio (Table h), Collection to wRVUs Ratio (Table i), wRVUs to Total Encounters Ratio (Table j)*

[x]*Participants of the Hospital Medicine Workforce Experience Survey includes: Employment Mode, Role, Predominant Schedule, Shifts Per Year, Typical Shift, Typical Shift Duration, Years Practicing as a Hospitalist, Age, Gender, Race, Region*

[xi]*Patient Census includes: Average Patient Census and "My Patient Census is Safe"*

[xii]*Paid Time Off and Benefits includes: Access to PTO, Ability to Use PTO without Negatively Affecting Colleagues and/or Patients, Employee Benefits*

[xiii]*Backup Systems includes: Have Voluntary Backup System, If Participants in Voluntary Backup Regularly Volunteer, Reasons They Don't Volunteer*

[xiv]*Well-being, Burnout and Engagement includes: Well-being, Burnout, and Engagement, Well-being by Participant Demographics, Well-being by Participant Workplace Structure*

Introduction

What is hospital medicine?

Hospital medicine is a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. Practitioners of hospital medicine include physicians ("hospitalists") and non-physician clinicians who engage in clinical care, teaching, research, and/or leadership in the field of general hospital medicine. Hospitalists manage and treat a significant range of complex and comorbid disease conditions. Hospitalists typically undergo residency training in general internal medicine, general pediatrics, or family practice. A minority of hospitalists specialize in fields including neurology, obstetrics and gynecology, and oncology.

For more information about hospitalists and hospital medicine, visit https://www.hospitalmedicine.org/.

Survey Process

Survey Design, Implementation, and Analysis

The group-level information presented in Sections 2 through 4 of this Report is derived from responses to the 2023 *State of Hospital Medicine* Survey. We largely retained the *SoHM* Survey from 2020, which was developed in partnership with the SHM Practice Analysis Committee. The data presented in Section 6 is derived from responses to the 2023 *Hospital Medicine Workforce Experience* Survey. For refinements to the 2023 *SoHM* Survey and for development of the new *Hospital Medicine Workforce Experience* Survey, SHM consulted with several volunteer members in an advisory capacity and to draw on specific subject matter expertise. The process for designing and implementing the 2023 *State of Hospital Medicine* and *Hospital Medicine Workforce Experience* Survey and Report included the following steps:

1. Refinement of *SoHM* and development of *Hospital Medicine Workforce Experience* surveys.
2. Development and testing of online survey instruments.
3. Release and promotion of survey.
4. Data cleaning, including identifying outliers and contacting respondents for validation on select responses.
5. Analysis of data and creation of data tables and graphs for publication in Report.

MGMA maintains its own independent survey development and implementation process for the data in Section 5 of this Report; please contact MGMA for details.

Target Population

The primary target population for SHM's *State of Hospital Medicine* Survey was hospital medicine group leaders (both physician leaders and non-physician practice administrators and executives) who are members or work alongside members of SHM. In addition, SHM promoted survey participation to its general membership via its website and a variety of electronic and print communications.

The target for the SHM *Hospital Medicine Workforce Experience* Survey was any practicing hospitalist. SHM promoted the survey to participants of the *State of Hospital Medicine* Survey, asking the respondents to share with their hospital medicine group members. SHM also promoted the survey with all members of the society.

Data Collection

SHM's *State of Hospital Medicine* Survey was conducted concurrently with MGMA's *Physician Compensation and Production* Survey from January 9, 2023 through February 10, 2023. Invitations for the survey were emailed to the target population. The survey was accessible via SHM's online survey portal. Respondents provided *State of Hospital Medicine* data about their practice either from the calendar year 2022 or from their 12-month fiscal year ending in 2022. The *Hospital Medicine Workforce Experience* Survey was conducted February 29, 2023, to March 13, 2023.

How to Use This Report

Report Organization

Six data sections appear in the Report:

- **Section 1:** Executive Summary and Overview. This section serves as an executive summary that highlights findings from both the SHM *State of Hospital Medicine* and *Hospital Medicine Workforce Experience* Surveys and MGMA *Physician Compensation and Production* Survey and ties information from various sections together.
- **Section 2:** *SoHM* Hospital Medicine Group Profile. This section provides basic group-level demographic information about SHM *State of Hospital Medicine* Survey respondents.
- **Section 3:** Hospital Medicine Groups Serving Adult Patients. This section provides detailed group-level information about scope of clinical services, staffing, schedules, compensation, and benefits, financial and selected academic information for hospital medicine groups that exclusively serve adult populations.
- **Section 4:** Hospital Medicine Groups Serving Pediatric Patients. This section provides detailed group-level information about scope of clinical services, staffing, schedules, compensation, and benefits, financial and selected academic information for hospital medicine groups that exclusively serve pediatric populations.
- **Section 5:** Hospitalist Compensation and Production. This section provides detailed compensation and productivity information for both academic and non-academic hospitalists, including both physicians and non-physician providers. The information in this section was prepared by and is licensed from MGMA.
- **Section 6:** Hospital Medicine Workforce Experience. This section provides data from the *Hospital Medicine Workforce Experience* Survey about the experience of practice structure and well-being and burnout.

Appendices

The appendices provide additional details about how survey information is defined, collected, and analyzed.

- **Appendix A** contains a glossary of common terms, abbreviations, and acronyms used in the Report, and their definitions.
- **Appendix B** details the methodology and formulas used in the analyses for the Report.
- **Appendix C*** contains a copy of the 2023 *State of Hospital Medicine* Survey instrument and guide.
- **Appendix D*** contains a copy of the 2023 *Hospital Medicine Workforce Experience* Survey instrument and guide.

***Note:** *Appendices C and D are available in the electronic version only. To reference either instrument, please go to hospitalmedicine.org/sohm.*

Additional Information

Please visit www.hospitalmedicine.org for more information about SHM and its practice management resources, or to purchase additional copies of this Report. Questions about this Report can be directed to survey@hospitalmedicine.org. Information about future surveys and any updates to this Report can also be found on SHM's survey website www.hospitalmedicine.org/sohm.

Statistical Interpretation – A User's Guide

Introduction

This *State of Hospital Medicine* Report uses descriptive statistics to summarize information about the hospital medicine groups that participated in the Survey, and about the compensation and productivity of individuals who practice in hospital medicine groups. The statistics displayed in various tables are:

- **Groups** – the number of practices or groups that reported the data used to create the variable;
- **Providers** – the number of physicians or providers represented by the data used to create the variable (predominantly appears in Sections 5 and 6);
- **Average** – the arithmetic mean calculated by summing the data and dividing by the count;
- **Standard deviation** ("Std Dev") – a statistical index of measuring the distribution of a data set relative to its mean;
- **25th percentile** ("25th %") – the value where one-quarter (25%) of the responses are lower and the remainder greater;
- **Median** – the midpoint of all responses when arrayed from lowest to highest, also known as the 50th percentile;
- **75th percentile** ("75th %") – the value where three-quarters (75%) of the responses are lower and the remainder greater; and
- **90th percentile** ("90th %") – the value where nine-tenths (90%) of the responses are lower and the remainder greater.

Interpreting the Data

Distribution of Individual Data Points within a Data Set.

The mean and the median are measures of central tendency in a set of data, but they do not reveal anything about the distribution of the individual data points. Some readers may assume that in the underlying hospital medicine population, the values for a given variable will tend to take the form of a 'normal' distribution – that is, a standard bell-shaped curve. Some of the data sets in this Report are highly variable in that the individual data points are widely distributed and not closely concentrated around the median. In other cases, the individual data points may roughly approximate a bell-shaped curve that is skewed in one direction or the other. In both cases the survey responses will not represent a normal distribution. It is important to understand that these variables may not always be normally distributed in the broader hospital medicine population, either.

Many of the variables for which data was collected in this survey – such as compensation, productivity, and turnover – will have a natural skew to the right or high side, since the lower boundary will always be zero but there is no upper limit and these values may be very high relative to the midpoint (median). In addition, it is very likely that some of the data elements – such as staffing levels and financial support – that are highly variable in the Survey data set are also broadly distributed in the underlying population and thus do not represent a normal bell-shaped distribution among hospital medicine practices across the country.

Average (Mean) vs. Median.

Generally speaking, the median is usually the most valuable data point for comparison when the goal is to compare one's own experience to the central tendency of the data set. Since the median is the midpoint of all data, it is often not subject to the same levels of distortion that may occur in the mean when extremely high or low values are present. In many cases in this Report, the mean is higher than the median, suggesting that the distribution is skewed to the right or high side. In other words, the values above the median are more widely dispersed (farther away from the mean) than the values below the median.

Standard Deviation.

The amount of variability within a data set is measured by the standard deviation. The standard deviation is an estimate of the average distance of data points away from the mean, based on the specific characteristics of a data set's distribution. In a normal (bell-shaped) distribution, 68% of the observed values will fall within one standard deviation of the mean. A standard deviation that is similar in value to the mean or higher than the mean indicates that the data is widely dispersed and there is weak central tendency. A standard deviation that is less than one-third of the mean indicates that the data is clustered relatively tightly around the mean and there is strong central tendency.

Many of the variables for which data is presented in this Report (such as compensation or financial support) do not tend to follow a typical bell-shaped distribution, however, and may thus have a high standard deviation relative to the mean. This does not mean that the results are not valid; it simply means the data points do not conform to a normal or bell-shaped distribution.

Sample Size.

In some cases, in which data is broken down and reported for multiple subcategories (for example, for four separate geographic sections), the number of data points reported for an individual subcategory may be small. In order to ensure respondent confidentiality and report only statistically meaningful values, results were suppressed if fewer than 10 data points were reported in the Adult section. SHM included responses at a lower threshold, 5 and above, for the Pediatric section so that demographic categories could be included.

The smaller the number of responses (the "n") for any data subset, the greater is the possibility that a single very high or very low value could influence the reported statistics. **Users should pay attention to the number of responses in any data subset and form their own opinions regarding the power and validity of the information presented.**

Correlation and Causation.

Many of the results presented in this Report tend to occur together much of the time. It is important, however, to distinguish between the presence of a correlation and the actual cause of that correlation. Do hospitalists in the South earn more simply because they live in the South? Or are there other factors – such as higher productivity, less-attractive work schedules, or a higher proportion of small practices in remote rural communities that make recruiting more difficult – that cause the higher compensation levels observed in the South? A key aspect to successfully interpreting numerical and statistical data is not to infer a causality where none exists.

Using the Survey Report

The data in this Report is highly representative of the respondent population but may not be representative of the overall population of hospital medicine groups. It is important that hospitalists and healthcare executives not approach this data as being representative of every practice or situation within hospital medicine nationwide. Instead, Report users should understand that one of the most valuable ways to use this information is as a set of external data by which to examine their practice. The information in this Report is a resource for the continuous process of measuring and comparing practice performance internally over time and externally to other organizations' experiences.

Physician leaders, practice administrators, and other users should consider examining the data in the following ways:

1. Which data points are the most meaningful comparators for your group? For example, do you want to compare your group against the universe of hospital medicine groups using national data, or will it be more useful to compare yourself to similar practices based on geographic region, practice ownership, or some other variable or combination of variables? Generally, it is best to examine survey results based on a variety of pertinent variables and to focus on a range of results across multiple practice characteristics rather than focusing on a single number.
2. How large is the sample size for the comparator(s) you have chosen? What is the standard deviation? How much difference is there between the median and the mean? How wide is the gap between the 25th percentile and the 75th percentile? Each of these factors can indicate how representative a reported statistical value is of individual hospitalists and hospital medicine groups.
3. What is the difference between your group's data and the reported median (or mean, if appropriate)? Are there situational factors that suggest you should be comparing yourself to the 25th, 75th, or 90th percentile rather than the median (or mean)?
4. Does the difference, if any, indicate that your group's performance is significantly out of line with the survey statistics? If so, are the differences explainable? For example, the method of data collection, survey definitions, specific circumstances, or organizational goals can all affect the outcome of comparison analysis. A substantial difference may highlight an area that requires managerial attention, but it might also simply reflect differences in practice environment or group characteristics.
5. By what methods can the variable you are evaluating be internally and/or externally changed or controlled?
6. How should your medical group measure performance for this variable? Do your systems and processes allow for the appropriate assessment of the indicator?

Other Important Points to Keep in Mind as You Use the Report

Data is self-reported and not independently verified.

We asked groups to report on a wide array of information about their operations, including specific numbers and financial figures. SHM cannot validate responses, but we do our best to exclude or otherwise reconcile outliers or what appear to be errors. We are only able to include what is reported to us through the Survey and there are multiple limitations that may influence the results, such as sample size, reporting bias, misunderstanding a question, and rounding or estimates made by respondents. We aim to have a representative sample of hospital medicine groups nationwide but recognize that some groups may not be as willing or able to participate in the data collection process.

Keep in mind the broader context of the data, including that it is retrospective.

This Survey was conducted early in 2023 but uses data from 2022. Be mindful that many groups were still experiencing disruptions due to COVID-19 (and other viral illnesses) in 2022 that may impact results and/or ability to participate in the Survey.

The Report tells us how things are, not how they should be.

The purpose of this Report is to provide information that helps inform groups' operational decisions, and better understand what is happening in hospital medicine groups around the country. The Report does not state how hospital medicine groups should operate or otherwise set standards for the field.

Refer to the Survey questions and glossary.

The Survey and Report try to use terms that are ubiquitous in hospital medicine; however, there may be cases where different groups may interpret questions or terms differently. Refer to the Survey instrument and glossary to better understand how the question was phrased and any clarifiers or definitions we might have used to try to standardize responses.